LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la.info

Approved 4/21/2015

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

April 16, 2015

MEMBERS PRESENT	MEMBERS ABSENT	PUBLIC	COMM STAFF/ CONSULTANTS
Grissel Granados, MSW, *Co-Chair*	Suzette Flynn	Bradley Land	Jane Nachazel
Fariba Younai, DDS, *Co-Chair*	David Giugni	Michael Pitkin	Yeghishe Nazinyan, MS, MD
Raquel Cataldo	Kimler Gutierrez *(pending)*		
Kevin Donnelly	Mitchell Kushner, MD, MPH		
Terry Goddard, MA	Maria Roman		**DHSP STAFF**
Ricky Rosales			Rhodri Dierst-Davies, MPH
Carlos Vega-Matos, MPA			

CONTENTS OF COMMITTEE PACKET

1) **Agenda**: Standards and Best Practices (SBP) Committee Agenda, *4/16/2015*
2) **Minutes**: Standards and Best Practices (SBP) Committee Meeting Minutes, *3/19/2015*
3) **Table**: Standards and Best Practices (SBP) Committee Work Plan, *4/16/2015*
4) **Memorandum**: "Specific-Populations" Definitions and Criteria, *10/8/2009*
5) **Memorandum**: New "Population-Specific" Guidelines: Framework and Format, *5/18/2015*
6) **Format**: Population-Specific Guidelines: Instructions and Formatting, *3/18/2015*
7) **Plan**: Los Angeles County Comprehensive HIV Plan 2013-2017, Key Populations in Los Angeles County, *2013*
8) **Plan**: Los Angeles County, California, HIV Prevention Plan, 2009-2013, Metro, Service planning Area, SPA 4, Priority Populations, *2009*
9) **Table**: County of Los Angeles, Division of HIV and STD Programs, Programs and Services, Continuum of Service Definitions by Funders Cross-referenced with COH Service Categories, Commission on HIV and Division of HIV and STD Programs, *3/18/2015*
10) **Graphic**: Continuum of HIV Services with Individual Determinants, *4/16/2015*
11) **Graphic**: Continuum of HIV care arrow-mapped to NHAS and service category indicators of DHSP-funded HIV care and support services in Los Angeles County, *4/16/2015*

1. **CALL TO ORDER**: Ms. Granados called the meeting to order at 10:12 am.

2. **APPROVAL OF AGENDA**:
   MOTION #1: Approve the Agenda Order, as presented or revised **(*Postponed*)**.

3. **APPROVAL OF MEETING MINUTES**:
   Motion 2: Approve the 3/19/2015 Standards and Best Practices (SBP) Committee meeting minutes, as presented or revised **(*Postponed*)**.

4. **PUBLIC COMMENT, *(Non-Agendized or Follow-Up)***: Mr. Pitkin asked for renewed attention to two aspects of the Commission's Guidelines for Conduct. He found staff side conversations at Commission meetings distracting and asked for needed discussions to move outside the conference room. He also urged SBP Co-Chairs to draw out more than one or two views during meetings.

5. **COMMITTEE COMMENT, *(Non-Agendized or Follow-Up)***: There were no comments.

6. **CO-CHAIRS' REPORT**: Ms. Granados reminded attendees of the Office of National AIDS Policy's listening session, Reducing New HIV Infections, on 4/22/2015, 10:00 am to 12:00 noon, at St. Anne's Maternity Home. The first of four regional sessions, feedback will be used to help inform the 2016-2020 update of the National HIV/AIDS Strategy (NHAS).

7. **STANDARDS OF CARE (SOC) WORK SCHEDULE**: This item was postponed.

8. **POPULATION-SPECIFIC GUIDELINES**: ➲ The Guidelines, Framework, Format and prior criteria were provided for SBP review.

9. **SERVICE CATEGORY DEFINITIONS**:
   - Mr. Vega-Matos reported the Service Definition Work Group reviewed the list of Commission service definitions. The list has historically presented a challenge in that definitions may not align with funder definitions. The Work Group agreed he would develop a mapping of Commission service definitions as they relate to funder definitions.
   - The Commission has used its service categories and definitions for Standards of Care (SOCs) and Priority- and Allocation-Setting (P-and-A). HRSA and CDC reporting requirements, however, use their own service categories and definitions. In the past, DHSP has received Commission allocations and converted them to HRSA and CDC definitions for reporting purposes.
   - The Service Definition Work Group recommended using funder service definitions as is consistent with the Commission's charge to allocate funds to funder-defined services. The Commission can target services by directive under those funder-defined services, e.g., Benefits Specialty Services would be funded under HRSA's Non-Medical Case Management.
   - He reviewed the new table of service categories which includes columns to reflect: HRSA/CDC service categories and definitions, funder limitations, Commission service categories, current HRSA or other funding, and comments. There are multiple other funding sources not managed by DHSP including: Ryan White Program Parts C, D and F; SAPC; Medi-Cal; Medi-Cal Waiver; Medicare; ACA; and other public and private insurance plans.
   - Mr. Land noted a recent consumer loss reported at the Commission and asked about warm hand-offs from hospitals to hospice. Mr. Vega-Matos replied that was a case management care coordination issue. DHSP is preparing a common language listing of DHSP-funded services and resources as a website reference. Hospice is not funded per se, but some facilities can convert an available bed to hospice. Mr. Goddard said Alliance for Housing and Healing sometimes converts a Residential Facility for the Chronically Ill bed to hospice to avoid moving a terminally ill client.
   - Additional staff are needed to meet Title XXII regulations on staffing ratios. Medi-Cal can cover that cost for eligible patients and DHSP can fund them for the uninsured. Some types of wounds or medical conditions require a skilled nursing facility.
   - DHSP funds Medical Nutrition Therapy with Net County Cost, but it is only offered in SPA 1, through Ryan White (RW) Ambulatory Outpatient Medical (AOM) or Food Bank/Home-Delivered Meal programs. Providers are increasingly concerned that Medi-Cal coverage requires documented kidney disease or kidney failure to access a Registered Dietician (RD). Many consumers require an RD, but RW-eligible AOM consumers have declined from approximately 18,000 to 7,000.
   - Mr. Land was concerned about gaps in general for those consumers accessing ACA or Medi-Cal, e.g., the Covered California formulary only requires a plan to offer one medication in a class of medications. Dr. Younai added she recently heard a proposal for up to $500 in out-of-pocket costs. Mr. Vega-Matos replied RW cannot offer additional medications, but advocates are addressing the formulary issue and the state plans to address share-of-cost through OA-HIPP expansion.
   - He noted the Commission funds Nutrition Support, HRSA's Food Bank/Home-Delivered Meals, with RW Part A. HOPWA also funded it until recently, but is halting funds as part of the alignment with Commission services approved last summer and fall. Instead, HOPWA will increase housing units, specialists and units while Part A absorbs their prior costs.
   - The Los Angeles Housing and Community Investment Department's new RFP was released a few weeks ago. Awards will be geographically based and require an MOU with a RW medical home that includes a housing specialist who will act as an entry point to the medical home and provide an onsite referral resource for the Medical Care Coordination (MCC) team.
   - Mr. Goddard added current contracts are being extended six months to allow time for potential applicants to review the 3,000 page RFP. Awards are expected to be announced in October 2015. Mr. Vega-Matos will draft a program guidance to AOM and MCC providers after awards are announced to discuss coordination. This culminates four years of discussions
   - The Commission's Referrals service category, HRSA's Referral for Health Care/Supportive Services, is not currently funded. Mr. Vega-Matos and Craig Vincent-Jones had discussed using it as part of Linkage to Care (LTC) with an information and referral mechanism and a DHSP/Commission MOU was developed, but there has been no recent activity on the subject.
   - DHSP funds Substance Abuse Treatment Residential Detoxification and Residential Rehab under HRSA's Substance Abuse Treatment-Residential. Treatment Adherence Counseling is embedded in AOM and MCC. Agencies receiving Part C and D

also fund services. HRSA now requires the agencies to request a letter of concurrence from DHSP to improve coordination. Their budgets and program proposals are part of the letter of concurrence request.

- Mr. Vega-Matos noted HRSA policy guidelines are included at the end of the HRSA service category Table 1 starting with Acupuncture Therapy. Guidelines are not service categories themselves, but address limitations on such services, e.g., Acupuncture Therapy is eligible for limited funding under Substance Abuse Treatment Services. HRSA has generally issued such guidelines as program notices in response to questions it has received.
- Vision Services is not a separate HRSA service category, but can be covered under AOM. Ophthalmology is now addressed through CHAIN and DHSP is working to add optometry. Glasses may only be funded through specific mechanisms that DHSP does not now have, e.g., health insurance premiums or a cost-sharing program. Advocacy could convince the state to add the service. Alternatively, a local mechanism could be developed, but doing so would be very complex.
- Some Commission service categories are ineligible for HRSA funds. They are listed at the end of Table 1.
- Table 2 reflects CDC service categories. Like HRSA, CDC requires 75% of grant fund expenditures on its prioritized services.
- HIV Testing Services includes: routine opt-out testing in healthcare settings; targeted testing in non-healthcare settings; routine HIV testing for pregnant women; and screening for STDs, hepatitis and tuberculosis in conjunction with HIV testing. DHSP has incentives for identifying new HIV+ people and for linking them to a medical home verified through surveillance.
- DHSP, as a public health entity, has access to surveillance data unavailable to Community-Base Organizations (CBOs) by statute. Many CBOs now receive CDC and private funds for LTC, but often activities are the same, e.g., outreach and directions to a clinic without confirming attendance. Often CBOs do not secure consent for a clinic to release information. DHSP hears from clinics receiving requests to help find patients, but the consent forms do not cover the data.
- MCC teams can, however, contact navigators who, as County employees, are able to access additional information to identify whether patients who have not been seen in six months have, e.g., changed clinics or left the state. Mr. Dierst-Davies noted 30% to 40% of patients that a particular clinic cannot find are in care elsewhere. By identifying those patients, efforts can focus on those out of care. He added LTC pertains to the newly diagnosed while re-engagement focuses on the needs of those who have left care. Amy Wohl, MPH, PhD and Sophia Rumanes, MPH will present on these efforts in June.
- Comprehensive prevention for PLWH is now funded by CDC, but could be shifted to RW depending on funding availability.
- Condom distribution to PLWH and those at highest infection risk and policy initiatives such as addressing structural barriers to instituting opt-out testing constitute the remaining prioritized service categories for 75% of grant funding.
- The main service categories for the remaining 25% of funds are: evidence-based interventions for high-risk populations; social marketing, media and mobilization; and funds for PrEP and nPEP education and linkage, but not medications.
- DHSP also receives extra CDC funding for expanded HIV testing for disproportionately affected populations. Testing targets high risk populations in and outside of healthcare settings. For the County, populations targeted are MSM, MSM of color and transgender populations. DHSP plans to release new RFPs for those services shortly.
- Mr. Vega-Matos is also developing a Table 3 on STDs. While not necessarily part of the Commission's current mandate, DHSP would like Commission input on how to address STDs since HIV+ MSM have a high STD incidence.
- The Service Definition Work Group reviewed the tables and recommended basing P-and-A and SOCs on funder service definitions. The Commission can further refine SOCs while tying them to funder definitions as is the Commission's role.
- Dr. Younai presented the revised Continuum of HIV Services overview which now starts with social determinants reflecting individual behaviors above the health behaviors and their associated interventions. In turn, they are supported by the local system of health services and, finally, local system fundamentals. Each area can be drawn out and quantified.
- Mr. Vega-Motos said the graphic synthesizes the Commission's planning functions and all the components that need to be reviewed in designing SOCs, reviewing service categories and data needed to evaluate, e.g., access and stigma.
- DHSP is engaged in an outcomes project to examine all DHSP-supported services to determine how they contribute to meeting NHAS goals. Mr. Vega-Matos presented a draft continuum based on NHAS goals which reflects services clustered along that continuum from prevention through to Viral Load (VL) suppression and reduced transmission with measurable outcomes for populations at each stage and service performance outcome measures.
- Processes have been measured, e.g., one Oral Health performance measure is how many patients complete a treatment plan in 12 months. The goal is to move to outcome, rather than process, measures to ensure ultimate goals are met. DHSP is currently focusing on services for PLWH, but plans to expand to prevention and STDs based on obtainable data.
- Mr. Vega-Matos noted services can be clustered along the continuum, e.g., services to prevent HIV and STDs; diagnostic services; linkage, retention and engagement services; HIV and STD treatment services; and VL suppression.
- Mr. Land asked if clustering would cause P-and-A issues in weighting services differently based on outcome measures. Mr. Vega-Matos noted evaluation methodologies vary by purpose. Planning, Priorities and Allocations (PP&A) determines need

and demand. The Los Angeles Countywide Coordinated HIV Needs Assessment (LACHNA) informs those purposes and requires a finite universe of clusters to assess awareness, need and receipt of services. For PP&A, services can be clustered by the HRSA/CDC definitions which would complete the assignment to develop service definitions for use in P-and-A.

- SBP addresses need, demand and outcomes, i.e., service impact on multiple performance levels. Demographic data reflects who accesses services to inform SBP's focus on social determinants of health; utilization reflects how services are used; and outcomes reflect impact on clients' quality of life. SOCs can be clustered by Commission definitions for evaluation.
- For publication, SOCs could be clustered as most people understand the HIV continuum, e.g., services for HIV- people; for PLWH unaware they are HIV+, who know they are HIV+ and are not in care, or PLWH who are in care; and support services that retain people in care such as substance abuse. Providers, regardless of funder, will mainly be interested in SOCs that define expectations for the populations they serve and services they provide. The SOC set preamble could provide foundational information on social determinants of health, inputs and outputs of a system of care, and the continuum.
- RW will not fund services covered by another funder, but will fund uncovered additional services. For example, if a plan covers 10 mental health visits for a patient who needs 16 then RW will fund the difference. RW will not augment covered services, e.g., for cultural competence or because covered mental health services are 40 miles away as has happened.
- Dr. Younai emphasized SOCs have always been developed to describe appropriate services for PLWH regardless of funder source. That must be maintained even as SBP becomes more thoughtful about DHSP's challenges in aligning SBP work with funding realities. Mr. Vega-Matos noted the Commission has a mandate to allocate according to HRSA or CDC defined service categories and develop SOCs that match service categories, but definitions can be refined to reflect local needs.
- DHSP is currently assessing the countywide need for Medical Nutrition Therapy.
- Mr. Vega-Matos will discuss the status of the Commission's Referrals service category, HRSA's Referral for Health Care/Supportive Services, with Mario Pérez, MPH who will bring the subject to the Executive Committee.
- SBP referred the Continuum of Service Categories by Funders to PP&A. The document satisfies requirements for SBP's assignment to identify service definitions for P-and-A purposes.
- The Service Definition Work Group will develop service clusters based on Commission service definitions for use in evaluation per the continuum and functional clusters to organize and publish the current set of SOCs. Work Group members are: Messrs. Donnelly, Goddard, Vega-Matos and Ms. Granados.
- Dr. Younai will incorporate the DHSP continuum graphic into the Continuum of HIV Services overview graphic.
- Dr. Younai and Doris Reed are completing a final edit of the existing SOC set. It will likely be done by next month.
- Mr. Vega-Matos will collaborate with Mr. Dierst-Davies on clustering LACHNA service questions pertaining to awareness of, need for and receipt of a service. Clusters should be consistent with the continuum.
- Ms. Nachazel will forward the PP&A 10/28/2014 meeting minutes to Mr. Dierst-Davies to help inform decisions on sampling methodologies. A specific population focused survey is a different sampling method than the planned generalized survey and affects generalizability of conclusions. The referenced meeting discussed PP&A goals for the LACHNA.
- Mr. Dierst-Davies reported unmet needs analysis is continuing. A report will likely be available by June.

10. **NEXT STEPS**: This item was postponed.
.

11. **ANNOUNCEMENTS**: There were no announcements.

12. **ADJOURNMENT**: The meeting adjourned at 12:15 pm.